REQUEST FOR APPLICATIONS **RFA # 2011-261**

TITLE: 1915 (b)/(c) Medicaid Waiver Expansion

FUNDING AGENCY: North Carolina Department of Health and Human Services, Division of Medical Assistance

ISSUE DATE: Friday, April 1, 2011

FUNDING AGENCY: DHHS, Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
Attn: Rachael Phillips, DMA Contracts Office

IMPORTANT NOTE: Indicate agency or organization name and RFA number on the front of each application envelope or package, along with the date for receipt of applications specified below.

Applications, subject to the conditions made a part of hereof, will be received until 5:00 p.m., Friday, May 20, 2011, for furnishing services described herein.

SEND ALL APPLICATIONS DIRECTLY TO THE FUNDING AGENCY ADDRESS SHOWN ABOVE.

Direct all inquiries concerning this RFA to the attention of:

Kelly Crosbie	and	Ken Marsh
NC Division of Medical Assistance		NC DMH/DD/SAS
RFA.Medicaidwaiver@dhhs.nc.gov		RFA.Medicaidwaiver@dhhs.nc.gov

NOTE: Questions concerning the specifications in this Request for Applications will be received until 5:00 p.m., Friday, April 15, 2011. Such questions should be directed via email to RFA.Medicaidwaiver@dhhs.nc.gov.

A summary of all questions and answers will be posted by Friday, April 22, 2011, on the websites of the Division of Medical Assistance at: http://www.ncdhhs.gov/dma/lme/MHWaiver.htm and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services at: http://www.ncdhhs.gov/mhddsas/waiver/index.htm.

Successful applicants will be chosen and notified only after the North Carolina General Assembly passes legislation for waiver expansion.

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INTRODUCTION

The North Carolina Department of Health and Human Services (DHHS) is initiating this request for applications (RFA) to solicit applications from local management entities (LMEs) to operate Medicaid funded services through capitated Pre-paid Inpatient Health Plans (PIHP). DHHS will select and contract with one or more qualified LME applicants that meet the Centers for Medicare and Medicaid Services (CMS) and DHHS regulatory and technical criteria, as well as industry standards for the administrative, clinical and financial operations of a PIHP. The requirements and criteria for participation in the waiver program are specified in this RFA.

In April 2005, DHHS began operating under two new waivers as a pilot project: (1) the Piedmont Cardinal Health Plan, a pilot 1915 (b) Freedom of Choice waiver project; and (2) the Innovations Home and Community Based services (HCBS) 1915 (c) waiver. In this pilot project, Medicaid funded services for mental health, substance abuse and developmental disabilities are provided on a capitation basis in a five-county area through a PIHP. PBH (formerly known as Piedmont Behavioral Healthcare), a local management entity (LME), operates the PIHP and manages state funded mental health, substance abuse and developmental disabilities services.

DHHS has elected to expand the pilot project beyond PBH to be phased in statewide. Toward this goal, DHHS submitted waiver amendment requests to CMS in December 2009 to expand the pilot project through modification of the existing Piedmont Cardinal Health Plan 1915(b) Freedom of Choice waiver, and modification of the 1915(c) Innovations Home and Community Based Services (HCBS) waiver. Waiver amendments are available for review on the DHHS Division of Medical Assistance (DMA) website at: http://www.ncdhhs.gov/dma/lme/MHWaiver.htm.

The two contracts resulting from this RFA will be administered by DHHS Division of Medical Assistance (DMA) and the DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The selected LME(s) will continue current obligations and commitment to the management of state funded mental health, substance abuse and developmental disabilities services as specified in a newly defined DMH/DD/SAS-LME performance contract in its entirety as attached to this RFA.

In February 2010, DHHS solicited applications from LMEs to operate capitated PIHPs for Medicaid-funded services. Four LMEs applied to operate PIHPs. On the basis of the application process, DHHS selected Mecklenburg County Area Mental Health, Developmental Disabilities, and Substance Abuse Authority and Western Highlands Network to be the next LMEs to participate in the State's Medicaid Waiver for mental health, developmental disabilities and substance abuse services. While these two LMEs move toward implementation in January 2012, DHHS will reissue the RFA to include other LMEs in the statewide implementation process. The other two LMEs (East Carolina Behavioral Health and Sandhills Center) that originally applied in 2010 do not need to reapply for participation. The Department has issued Plans of Correction to these LMEs and will work with them to begin managed care operations by July 2012. These LMEs will need to pass readiness reviews prior to beginning operations.

This is the final RFA that will be issued for statewide expansion. Full expansion is expected to be completed by January 1, 2013. LMEs that apply will be expected to be fully operational by January 1, 2013. LMEs may choose to apply individually, if they meet minimal requirements (see below) or they may form organizational arrangements with other LMEs (see below).

Acronyms

CABHA	Critical Access Behavioral Health Agency
CFR	Code of Federal Regulations
CMS	The federal Centers for Medicare and Medicaid Services http://www.cms.hhs.gov/
DD or I/DD	Developmental disabilities or intellectual and/or developmental disabilities
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance, a division of DHHS and North Carolina's State Medicaid Agency
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities and Substance Abuse Services, a division of DHHS
HCBS	Home and Community Based Services
HIPAA	*Health Insurance Portability and Accountability Act* enacted by U.S. Congress in 1996
ICF-MR	Intermediate Care Facility for the Mentally Retarded
MCO	Managed care organization
PBH	The LME formerly named Piedmont Behavioral HealthCare
PIHP	Prepaid Inpatient Health Plan – see below
PMPM	Per member per month
UM/UR	Utilization management / utilization review – see below

Definitions

Action	The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the LME to act within the timeframes provided in 42 C.F.R. 438.408(b). For a rural area resident with only one LME, the denial of a Medicaid Enrollee's request to obtain services outside the Provider Network: a. From any other provider in terms of training, experience, and specialization) not available in the network. b. From a provider not part of the network that is the main source of a service to the recipient—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the Enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days. c. Because the only plan or provider available does not provide the service because of moral or religious objections. d. Because the Enrollee's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.

Appeal	A request for administrative review of an Action as defined above.
Grievance and Appeal Procedure	The written procedures pursuant to which Enrollees may express dissatisfaction with the provision of services by the LME and the methods for resolution of Enrollee grievances and appeals by the LME.
Critical Access Behavioral Health Agency	Critical Access Behavioral Health Agency (CABHA) is a new category of provider agency, approved by DHHS and CMS. CABHAs are designed to ensure that critical services are delivered by a clinically competent organization with appropriate medical, clinical, and quality management oversight and the ability to deliver a continuum of services.
Capitation Payment	A fixed payment remitted at regular intervals by DMA to the LME(s) operating a PIHP. The LME determines whether their providers are paid fee for service or on a capitated basis.
Care Management	A multidisciplinary, disease centered approach to managing medical care using outcome measures to identify best practices. The purpose of care management is to identify level of risk, stratify of services according to risk, and prioritize recipients for services. The approach utilizes collaboration of services, systematic measurement and reporting and resource management.
Clean Claim	A clean claim is a claim that can be processed without obtaining additional information from the provider of the services or from a third party. It does not include a claim under review for medical necessity, or a claim that is from a provider that is under investigation by a governmental agency for fraud or abuse.
Complaint	See grievance.
Covered Services	The services identified in the waiver application and in the contract that the LME agrees to manage pursuant to the terms of the contract.
Cultural Competency	The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of mental health, developmental disabilities and substance abuse services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.
Days	Unless otherwise noted, refers to calendar days. "Working day" or "business day" means day on which DHHS is officially open to conduct its affairs.
Department	The North Carolina Department of Health and Human Services
Enrollee	A person who is on Medicaid and in one of the mandatory eligibility groups included in the waiver is automatically enrolled in the PIHP regardless of whether s/he ever accesses services.

Evidence based	A program or practice that has had multiple site random controlled trials demonstrating that the program or practice is effective for the population served.
Fee-for-service	A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to Recipients based on the payment methods set forth in the State Plan and the applicable policies and procedures of DMA.
Grievance	An expression of dissatisfaction by or on behalf of an Enrollee about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the LME level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights).
Hearing	A formal proceeding before an Office of Administrative Hearing Law Judge in which parties affected by an action or an intended action of DHHS shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.
Innovations Waiver	The current NC 1915 C home and community based services waiver (HCBS) currently operated by PBH and for which application has been made for statewide implementation. The Innovations Waiver replaces the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) in the Piedmont counties.
Insolvency	The inability of the LME to pay its obligations.
Managed Care Organization (MCO)	An umbrella term for health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of providers, physicians and hospitals.
Medical Necessity	Treatment that is a. Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition; b. Consistent with Medicaid policies and National or evidence based standards, North Carolina Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided; c. Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care; d. Not provided solely for the convenience of the recipient, recipient's family, custodian or provider; e. Not for experimental, investigational, unproven or solely cosmetic purposes; f. Furnished by or under the supervision of a practitioner licensed

	(as relevant) under State law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable Federal and state directives; g. Sufficient in amount, duration and scope to reasonably achieve their purpose, and h. Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment. Within the scope of the above guidelines, medically necessary treatment shall be designed to: a. Be provided in accordance with a person centered service plan which is based upon a comprehensive assessment, and developed in partnership with the individual (or in the case of a child, the child and the child's family or legal guardian) and the community team; b. Conform with any advanced medical directive the individual has prepared; c. Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and d. Prevent the need for involuntary treatment or institutionalization.
Network Provider	A provider of mental health, developmental disabilities and substance abuse services that meets the LME's criteria for enrollment, credentialing and/or accreditation requirements and has signed a written agreement to provide services
Prepaid Inpatient Health Plan (PIHP)	An entity that 1) provides medical services to Enrollees under contract with the State Medicaid agency; 2) on the basis of prepaid capitation payments or other payment arrangements does not use State plan payment rates; 3) provides arranges for or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and 4) does not have a comprehensive risk contract.
Prior authorization	The act of authorizing specific services before they are rendered.
Provider	Any person, agency or entity providing mental health, developmental disabilities, or substance abuse services.
Provider Network	The agencies, professional groups, or professionals under contract to the LME that meet LME standards and that provide authorized Covered Services to eligible and enrolled persons
Recipient	An Enrollee who is receiving services.
Reconsideration	An enrollee's first step in the appeal process after an adverse organization determination; the LME-PIHP shall have procedures to reevaluate an adverse organization determination, findings upon which it was based, and any other evidence submitted or obtained.

Recovery	The processes by which people are able to live, work, learn and participate fully in their communities.
Resilience	The personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives.
Risk Contract	A contract under which the contractor: 1) assumes risk for the cost of the services covered under the contract; and 2) incurs loss if the cost of furnishing the services exceeds the payments under the contract. This contract is a risk contract because the LME assumes that risk that the cost of providing Covered Services to Enrollees may exceed the capitation rate paid by DHHS.
Risk Reserve	A restricted reserve account maintained by the LME to fund payments for outstanding obligations, such as cost overruns related to Medicaid program services.
Self-determination	Self-determination refers to the right of individuals to have full power over their own lives, regardless of presence of illness or disability. Self-determination in the mental health system refers to individuals' rights to direct their own services, to make the decisions concerning their health and well-being (with help from others of their choice, if desired), to be free from involuntary treatment, and to have meaningful leadership roles in the design, delivery, and evaluation of services and supports.
Service Management Record	A record of Enrollee demographics, authorizations, referrals, actions and services billed by Network Providers
State	The State of North Carolina
State Plan	The "State Plan" submitted under Title XIX of the Social Security Act, Medical Assistance Program for the State of North Carolina and approved by CMS
Subcontract	An agreement which is entered into by the LME in accordance with Section 11
Subcontractor	Any person or entity which has entered into a contract with the LME.
Third Party Resource	Any resource available to a Member for payment of expenses associated with the provision of Covered Services (other than those which are exempt under Title XIX of the Act), including but not limited to, insurers, tort-feasors, and worker's compensation plans
Utilization Management (UM)	A system's overall strategy for managing service utilization by individual clients and by the system as a whole. UM is implemented through a plan that combines care management, resource management, UR, and uses financial data to determine trends and service use patterns
Utilization Review (UR)	The process used to evaluate requested health care services and determine whether they are medically necessary
Waiver	The document by which DHHS, DMA, requests sections of the Social Security Act (SSA) be waived, in order to operate a capitated managed care system to provide services to enrolled recipients.

	Section 1915 (b) of the SSA authorized the Secretary to waive the requirements of sections 1902 of the SSA to the extent he or she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost-effective, efficient, and consistent with the objectives of the Medicaid program. Section 1915 (c) of the SSA provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings as the Medicaid alternative to providing comprehensive long-term services in institutional settings. Initial waivers are approved for three years. Renewed waivers are granted for five years.

BACKGROUND

In 2009, the Department of Health and Human Services (DHHS) initiated a collaborative effort with the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) with the goal of restructuring the delivery system for Medicaid funded mental health, substance abuse and developmental disabilities services. The new delivery system will operate on a capitation basis and will be phased in statewide.

DMA manages North Carolina's Medicaid health insurance program for low-income individuals and families including parents, children, seniors, and people with disabilities. The Medicaid program includes coverage of mental health, developmental disabilities and substance abuse services.

DMH/DD/SAS has specific responsibilities for the provision of publicly funded services for individuals in the State with mental health and substance abuse problems and/or with developmental disabilities. Furthermore, DMH/DD/SAS is responsible for the programmatic oversight of the use of funds allocated by the General Assembly for these purposes, including those provided by federal block grants.

At the local level, the DMH/DD/SAS oversees mental health, developmental disabilities and substance abuse services through a network of area authorities / county programs that cover the state's 100 counties. As a result of system reform undertaken in 2001, the role of area authorities / county programs changed from service provider to service manager as they became local management entities (LMEs). LMEs develop community capacity through service provider contracts, expand partnerships with formal and informal community organizations and engage individuals with disabilities in planning and policy implementation. Most services are now provided through the private sector.

In the process of reform, DHHS established one LME as a pilot project through the use of 1915(b) and 1915(c) Medicaid waivers to serve individuals with mental health, developmental disabilities and substance abuse needs who are eligible for Medicaid. While remaining responsible for state allocated funds including federal block grants and for all applicable rules and policies, PBH (formerly known as Piedmont Behavioral Health) began delivering Medicaid State Plan funded mental health and substance abuse services through the Piedmont Cardinal Health Plan, a capitated model known as a prepaid inpatient health plan (PIHP). PBH also began delivering Home and Community Based Services and supports through the Innovations waiver, a 1915(c) waiver for individuals with mental retardation or developmental disabilities. The Innovations waiver replaced the State's Comprehensive and Supports waivers in the PBH catchment area. Accordingly, PBH assumed risk for mental health and substance abuse services (including inpatient, clinic option and rehabilitation option services) through the Piedmont Cardinal Health Plan, and for Home and Community Based Services under the Innovations waiver.

PBH has operated a PIHP in five counties since April 1, 2005. All Medicaid recipients in those counties that are included in eligibility groups covered under the 1915 (b)/(c) waiver were mandatorily enrolled with PBH operating the single PIHP on April 1, 2005.

Since the inception of these waiver programs, North Carolina has demonstrated that the State can provide quality mental health, developmental disabilities and substance abuse services through private and public sector cooperation and at a lesser or comparable cost than the fee-for-service (FFS) program costs for the Medicaid eligible population.

In 2009, DHHS elected to expand the 1915 (b)/(c) Medicaid waiver statewide with the intent to establish additional LMEs operating a PIHP under both waivers. This RFA establishes the requirements for a LME to operate a PIHP. CMS approved expansion in spring 2010. Based on CMS approval, DHHS will select and contract with additional LME(s) to operate Medicaid funded services through a capitated PIHP.

With the recent passage of health care reform, Medicaid coverage will expand to include the health and behavioral health needs of a larger percentage of the population. The Affordable Care Act (ACA) promotes the integration of behavioral health and primary health care. This integration results in improved access and improved quality of services for those in need of behavioral healthcare. The goals for healthcare reform and the States expansion of the 1915 b/c waiver are similar in that they both focus on cost containment while focusing on increased quality, access, and prevention to improve care.

Goals for North Carolina

DHHS has three primary goals for the statewide expansion of the 1915 (b)/(c) Medicaid waiver, including:

- Improved access to behavioral health and primary care services.
- Improved quality of all services.
- Improved cost benefit.

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The performance of the system will be measured over the long term as LMEs operating a PIHP are included in the 1915 (b)/(c) Medicaid waiver to determine how well the strategy meets these primary goals for North Carolina.

SCOPE OF WORK

If approved for participation in North Carolina's 1915 (b)/(c) Medicaid waiver program, an LME will be eligible to enter into a contract with DMA to operate a prepaid inpatient health plan (PIHP) for the delivery of Medicaid covered mental health, developmental disabilities and substance abuse services. LMEs operating a PIHP will be responsible for complying with all terms and conditions of a contract between the Division of Medical Assistance and the Local Management Entity (referred to as the DMA Contract), including but not limited to: recruiting and credentialing providers, developing and overseeing a comprehensive MH/DD/SAS provider network that assures timely access to services for all enrollees, authorizing payments for services, processing and paying claims, and conducting care management, utilization management and quality management functions. DMA will pay each participating LME per member/per month (PMPM) capitated payments. See the attached sample DMA Contract for a delineation of all financial requirements and agreements including PMPM calculations and 3rd party liability (Section 10).

LMEs must also comply with the contract between the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Local Management Entity (referred to as the DMH/DD/SAS Contract) in its entirety. See the attached sample DMH/DD/SAS Contract. Note DMHDDSAS contract reflects the same format as DHHS-LME performance contract while complementing the enhanced roles and responsibilities of an LME operating a PIHP.

For the purposes of the DMA Contract, Medicaid covered services are enhanced mental health and substance abuse services, inpatient services, outpatient services, psychiatric residential treatment facilities, residential treatment services, emergency room treatment for MH/DD/SA and intermediate care facilities for individuals with mental retardation, as defined in DMA clinical coverage policies 8A through 8J. Clinical coverage policies are located on the DMA website at: http://www.dhhs.state.nc.us/dma/mp/index.htm. In addition, Medicaid covered services under this contract include Innovations waiver services and 1915(b)(3) services as defined in the Innovations 1915 (c) waiver and the 1915(b) Medicaid waiver. See the 1915(b)/(c) waivers and waiver amendments posted on the DMA and the DMH/DD/SAS websites.

Enrollment in the PIHP will be mandatory for every Medicaid recipient whose county of residence for Medicaid purposes is located in the geographic area covered by the PIHP. See attachment J of the DMA Contract. Enrollment of Medicaid recipients will be automated through DMA's Medicaid Management Information System.

The capitation rates paid each month by DMA for each Medicaid recipient residing in the covered geographic coverage area, including retroactive payments and adjustments, are considered payment in full for all services to be provided under the DMA Contract, including all administrative costs. These rates will be certified as compliant with the Centers for Medicare and Medicaid Services (CMS) requirements under 42 C.F.R. 438.6(c) by actuaries meeting the standards of the American Academy of Actuaries. The State will assist the LME with risk reserve development by adding an additional 2% to the monthly capitation payment until the risk reserve has reached the required capacity to begin funding the risk reserve account. Refer to Section 10 of the Statement of Work of the DMA Contract for more information on capitated payments and Attachment Q for a description of the rate-setting methodology.

For consideration as an applicant for operating a PIHP, the LME must understand and be prepared to comply with the DMA Contract in its entirety, as well as respond to the particular requests for

information as outlined in this RFA. Submission of an application in response to this RFA indicates agreement to comply with the DMA Contract, the DMH/DD/SAS Contract, and the requirements specified in this Scope of Work. The LMEs must begin full operations no later than January 1, 2013.

Minimum Requirements

To be considered by DHHS as an applicant to operate a PIHP and to participate in North Carolina's 1915 (b)/(c) Medicaid waiver, an LME must have a current contract with DHHS and must fully meet all of the minimum requirements shown in table 1. Attestation to and/or evidence of such shall be provided by completing the Minimum Requirements Checklist located in appendix C of this RFA.

These minimum requirements are viewed as necessary to meet North Carolina's goals for improved access, quality of services and cost benefit. For example, the requirement for the Medicaid eligible population size is necessary to provide the LME operating a PIHP with the minimally adequate funding to support Medicaid services, to make 1915 (b)(3) services available, and to establish the needed risk reserve as described below under Additional Requirements.

DHHS will select the LME(s) and will make all State and Medicaid capitated funding payments to the LME designated in the application to operate the PIHP and to manage state funded services. Each of the two DHHS contracts (DMA & DMHDDSAS) shall be with the designated LME. An applying LME may propose a variety of organizational arrangements.

- A single LME that performs all managed care organization (MCO) functions independently or subcontracts specific functions to one or more public, private or non-profit vendor(s) within the limits outlined in the subsequent paragraphs and throughout the RFA.
- A merger of two of more LMEs. (Per G.S. 122C-115.3(a) a full merger can only become effective at the start of a new state fiscal year.)
- An intra-governmental agreement among two or more LMEs. In this agreement, the LMEs must choose a single lead LME for both the DMA and DMHDDSAS contracts. The LME agreement must specify how all managed care and LME functions are met for all counties included in the agreement.

By the date of RFA application submission, all LMEs must identify which lead LME they will partner with to perform the required Medicaid managed care functions and LME functions. If LMEs do not identify working partners, then DHHS will assign LME catchment areas to the chosen LME-MCO vendors for both DMA managed care and LME functions by January 1, 2013. LMEs may choose to partner with those LMEs already performing or in the process of starting managed care functions for Medicaid services.

This RFA will allow applying LMEs to subcontract some functions required by the DMA or DMHDDSAS contracts to another LME or to a commercial vendor(s), which are capable of performing managed care organizational functions, enabling an applying LME to fully meet the minimum and additional requirements of the RFA more quickly, thus facilitating a highly competitive application. The applying LME is responsible for all of its own and its subcontractors' activities and must submit as part of its application all contractual agreements and/or subcontracts in sufficient detail to demonstrate how all subcontracted function(s) will operate and be managed by the LME.

The following managed care functions may be subcontracted: Information Technology/Systems; Claims Processing; Customer Service; Provider Enrollment, Credentialing, and Monitoring; Professional Consultation; and Peer Review.

Finally, the applying LME must meet the statutory requirements of NC General Statutes 122C Article 4, Part 2.

Table 1 specifies the minimum requirements that must be fully met in order for an application to be considered by DHHS. The Minimum Requirements Checklist shown in appendix C must be completed by the applicant and submitted to DHHS including all requested evidence of compliance in one packet. Appendix C provides additional instruction and detail about the required evidence to be submitted.

Note that in table 1, the phrase "the LME applying to operate a PIHP" refers to any of the above organizational arrangements.

Table 1. Minimum Requirements (Pass/Fail)
1. The LME applying to operate a PIHP has an unduplicated minimum Medicaid eligible population of 70,000 individuals ages 3 years and older and a total population size of 300,000 (by July 2012) and a total population size of 500,000 by July 2013. (See tables 2 & 3 below)
2. The LME applying to operate a PIHP does not provide State funded or Medicaid reimbursable services (i.e., totally divested of all services at the date of application submission).
3. The LME applying to operate a PIHP is currently fully accredited for a minimum of three (3) years through an accrediting body approved by DHHS, and agrees to become URAC or NCQA accredited by the end of one year of operating the PIHP.
4. The LME applying to operate a PIHP has met the requirements to receive State service dollars through single stream funding.
5. The LME applying to operate a PIHP has financial resources (i.e., fund balance or financial support from the county if a single county LME) sufficient to develop and put into operation an infrastructure to meet all requirements of the transition, implementation, and ongoing performance of all of the functions of a managed care organization, as evidenced by independent audits and other State financial records with no significant findings.
6. The LME applying to operate a PIHP shall provide a written letter of support from the LME Board of Directors to approve and obligate the resources required to develop the infrastructure to operate the PIHP and to assume the financial responsibility for operating the PIHP. In the case of a single county LME applying, the LME shall provide a written letter from the Board of County Commissioners to approve and obligate the resources required to develop the infrastructure to operate the PIHP and to assume the financial responsibility for operating the PIHP.
7. The applying LME must provide a letter of intent that is signed by all parties describing the relationship of the parties with respect to management and business functions, roles and financial arrangements within the newly proposed managed care organization (DMA contract). The letter of intent among two or more LMEs will also specify the commitment to merge or the commitment to designate the lead LME and the subcontracted LME functions performed by the other LMEs in the agreement (DMHDDSAS contract). ["All parties" includes other LMEs and subcontractors.]
8. Neither the LME, nor any employee of the LME, applying to operate a PIHP shall serve as legal guardian for any recipient of Medicaid reimbursed mental health, developmental disabilities or

Table 1. Minimum Requirements (Pass/Fail)
substance abuse services.
9. The LME applying to operate a PIHP shall not contract with, or make any referral of a recipient to, any provider entity in which the LME or any member of the LME staff or a board member has an interest. • *Interest* means having a familial or financial relationship with the provider agency or any of its investors, owners, board members or employees. • *Financial relationship* means contractual or employment arrangement; arrangement involvement a commission, reward, or other financial, material or tangible consideration or benefit.
10. The LME applying to operate a PIHP shall maintain professional liability insurance for itself and its professional staff with limits of at least ($1,000,000) per occurrence and at least ($3,000,000) in the aggregate throughout the terms of the contract by the time the contracts are signed.
11. The LME applying to operate a PIHP must possess or can subcontract for and maintain an automated management information system capable of performing all the activity, interfacing and reporting requirements of a managed care organization utilizing electronic data interchange using HIPAA transactions, including claims adjudication, third party coordination, eligibility maintenance, membership reconciliation, provider and fee schedule maintenance, capitation payment reconciliation, financial reporting and encounter data creation and submission. The system must have the ability for provider access to check the status of their service authorization requests, claims submission and claims payment status. The system shall be fully capable of supporting and carrying out all required managed care functions 60 days before the start date.
12. The LME applying to operate a PIHP shall provide letters of support from the local Consumer and Family Advisory Committee (CFAC) of the LME that is submitting the application plus letters of support from any other CFACs that are part of the total configured population.
13. The LME applying to operate a PIHP agrees to abide by all requirements contained in this RFA and the DMA Contract and the DMH/DD/SAS Contract attached to this RFA, and any subsequent changes negotiated in future contracts or as required by the federal Centers for Medicare and Medicaid Services (CMS).
14. The LME applying to operate a PIHP must hold a minimum of one (1) stakeholder meeting providing accurate information regarding the waiver and must submit minutes of the meeting as evidence.
15. The LME shall provide a letter of commitment to be operational no later than January 1, 2013 and to pass two readiness reviews prior to start date and that indicates the understanding that failure to meet these benchmarks will result in termination of the award.

The decision to undertake the operation of a PIHP and to participate in the 1915 (b)/(c) waiver must be made with the agreement and support of an LME's Board of Directors (or the Board of County Commissioners if a single county LME applies) and with the local Consumer and Family Advisory Committee (CFAC). Likewise, the decision to participate in a new organizational arrangement will also involve each LME's Board and CFAC. Letters of support from each confirm the understanding of

responsibilities and support of all parties in this new endeavor. Note that in a merger or other multiple LME organizational arrangement, the counties are not required to be contiguous.

Note that DHHS will require consistency in the administration of the 1915 (b)/(c) waiver across the State through basic guidelines and requirements such as credentialing, utilization management, data management, reporting, performance measures, and other key functions. To this end, DHHS has adopted the PBH model of managed care operations. The following forms and business processes will be standardized:

Customer Service

- Consumer Handbook (elements)
- Consumer Grievance & Appeals Processes & Due Process Letters

Quality Management

- Consumer Survey (elements)
- Provider Survey (elements)
- Performance Measures
- Dashboard Reporting format
- (c) Waiver reporting format

Utilization Management/Care Management

- Treatment Planning Model (MH/SA/DD)
- Authorization Request Forms
- Person Centered Plan (MH/SA)
- Innovations
    - Individual Service Plan (ISP)
    - Level of Care (LOC) tool & process
    - All PBH Innovations forms
    - Self Direction model
    - 'Relative as Provider' forms & model
    - Supports Intensity Scale (SIS)/Supports Needs Matrix

Provider Network

- Provider Handbook (elements)
- Enrollment/Credentialing process & forms
- Provider (evergreen) contracts
- Provider Monitoring
- Provider Report Card
- Provider Appeal Process

For purposes of responding to this RFA, use Tables 2 & 3 to determine a LME's eligibility for meeting the first minimum requirement, i.e., an unduplicated minimum Medicaid eligible population of 70,000 individuals ages 3 years and older and total population count. To meet this minimum requirement, other LMEs may choose one of the alternative organizational arrangements described above with one LME applying as the lead.

Table 2. Medicaid Eligible Individuals September 2010 for RFA Waiver Application Minimum Requirement #1

Source: DMA's management information system, DRIVE Client-Population table, report date Jan. 12, 2011

LME code	LME Name	age= 0-2	age= 3-17	age= 18-64	age= 65-200	Grand Total	Requirement (Total less ages 0-2)
101	SMOKY_MTN	11,060	36,002	34,018	13,069	94,149	83,089
102	WESTERN_HIGHLANDS	10,691	33,437	31,396	10,556	86,080	75,389
108	PATHWAYS	9,053	29,529	29,070	7,890	75,542	66,489
109	CATAWBA	5,783	17,800	14,106	4,436	42,125	36,342
110	MECKLENBURG	21,674	61,024	44,748	9,572	137,018	115,344
112	PIEDMONT	16,040	48,574	37,453	10,531	112,598	96,558
201	CROSSROADS	5,700	18,129	14,679	5,038	43,546	37,846
202	CENTERPOINT	12,327	37,401	29,731	8,568	88,027	75,700
204	GUILFORD	10,788	32,063	25,821	6,871	75,543	64,755
205	ALAMANCE_CASWELL	4,308	12,452	9,863	3,315	29,938	25,630
206	OPC	3,716	10,716	8,677	2,979	26,088	22,372
207	DURHAM	6,905	17,852	14,496	2,948	42,201	35,296
208	FIVE_COUNTY	6,008	20,425	21,500	6,906	54,839	48,831
303	SANDHILLS	13,964	43,983	35,369	10,795	104,111	90,147
304	SOUTHEASTERN_REG	9,054	30,277	29,933	8,702	77,966	68,912
305	CUMBERLAND	7,681	24,344	23,035	3,893	58,953	51,272
307	JOHNSTON	4,142	12,670	10,008	2,841	29,661	25,519
308	WAKE	14,924	40,437	27,235	6,726	89,322	74,398
401	SOUTHEASTERN	6,654	20,689	19,908	4,815	52,066	45,412
402	ONSLOW_CARTERET	3,769	11,108	10,734	2,533	28,144	24,375
405	BEACON	7,346	23,388	20,983	6,797	58,514	51,168
407	ECBH	13,182	42,287	41,025	13,631	110,125	96,943
413	EASTPOINTE	8,933	27,914	23,081	7,700	67,628	58,695
	Total	213,702	652,501	556,869	161,112	1,584,184	1,370,482

Table 3. Total Population September 2010 for RFA Waiver Application Minimum Requirement #1

LME code	LME Name	1 age= 0-2	2 age=3-17	3 age= 18-64	4 age= 65-200	Total Population	subtotal age>=3
101	SMOKY_MTN	16,580	87,851	325,560	96,381	526,372	509,792
102	WESTERN_HIGHLANDS	17,174	86,886	310,231	96,766	511,057	493,883
108	PATHWAYS	14,669	75,346	243,115	52,339	385,469	370,800
109	MHP	9,054	47,384	157,124	35,396	248,958	239,904
110	MECKLENBURG	44,023	187,682	596,495	80,980	909,180	865,157
112	PIEDMONT	29,653	153,584	471,282	89,883	744,402	714,749
201	CROSSROADS	9,991	54,141	169,866	38,054	272,052	262,061
202	CENTERPOINT	21,037	104,784	342,166	74,831	542,818	521,781
204	GUILFORD	18,900	93,192	311,190	60,081	483,363	464,463
205	ALAMANCE_CASWELL	6,575	33,061	109,860	24,217	173,713	167,138
206	OPC	7,697	38,196	160,455	29,312	235,660	227,963
207	DURHAM	13,422	53,171	178,686	26,301	271,580	258,158
208	FIVE_COUNTY	8,689	45,804	150,173	31,783	236,449	227,760
303	SANDHILLS	22,795	111,722	342,818	78,223	555,558	532,763
304	SOUTHEASTERN_REG	11,499	56,626	157,951	31,465	257,541	246,042
305	CUMBERLAND	17,416	69,554	207,507	29,748	324,225	306,809
307	JOHNSTON	7,518	36,781	112,164	17,137	173,600	166,082
308	WAKE	40,393	184,090	623,014	72,441	919,938	879,545
401	SOUTHEASTERN	12,472	56,864	227,787	63,843	360,966	348,494
402	ONSLOW_CARTERET	13,198	49,574	156,384	27,960	247,116	233,918
405	BEACON	10,194	50,558	156,284	33,419	250,455	240,261
407	ECBH	23,707	111,003	371,601	88,302	594,613	570,906
413	EASTPOINTE	12,603	61,340	180,709	39,291	293,943	281,340
	Total	389,259	1,849,194	6,062,422	1,218,153	9,519,028	9,129,769

Application Narrative

The pages that follow identify specific criteria the LME must meet and for which the LME must provide additional evidence in the application as it relates to a managed care functions and not how current LME functions operate. The DMA Contract reference number associated with the requirements is given where applicable. Specific items the LME must address are included in this section of the RFA for ease of review by the Evaluation Committee. Note that the RFA does not request evidence for every item in the DMA Contract. However, if an applicant qualifies otherwise, all DMA Contract items along with those referenced in the RFA as determined by DHHS may be examined as part of an onsite review during the evaluation and selection process.

Also, note that the RFA uses terminology in accordance with CMS. Terms such as “care management” or “customer services” may differ from traditional usage in North Carolina; therefore, take care to check such definitions using the Definitions table provided in the Introduction and the attached DMA contract.

Clinical Operations

DMA contract section Reference #	Clinical Operations

6.7	***Customer Services***
	(Limit to 5 pages exclusive of the organization chart and job description.)
	
	The LME shall provide Enrollees with toll-free telephone access and emergency referral, either directly or through its Network Providers, twenty-four (24) hours per day, seven (7) days per week.
	• Provide a detailed organization chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing customer service functions. Identify both current positions (note if filled or vacant) and planned future positions.
	• Submit the proposed job description for these positions.
	• Describe the work flow process for each of the functions in 6.7 of the DMA Contract. Include the steps for linking calls to care managers.
	• Describe how emergency calls will be managed by customer services, during regular hours and during weekends or after hours. Address the following items:
	  • How it is determined that an emergency exists.
	  • How the caller is connected with an individual or service that can help him or her.
	  • Describe the interface with crisis services and 911/fire/rescue.
	  • Indicate the licensure requirements for those responsible for call resolution and required follow-up.
	• Describe the process from the time the member or provider contacts the LME to request services through the time of first appointment. Address how the LME:
	  • Provides enrollees with real choice among the providers.
	  • Handles requests for out-of-network and out-of-region providers.
	  • Assures providers are accepting new referrals.
	  • Confirms the individual was seen in a timely manner.
	  • Conducts follow-up with individuals who do not show up for routine appointments.
	  • Addresses and tracks requests to change providers.
	• Describe how customer services will respond to calls related to grievances and appeals.
	• Describe the LME's training plan for customer service staff including approaches to assure consistency among staff in responding to calls.

6.10 6.11 6.14	***Enrollee Education*** (Limit to 2 pages exclusive of the materials and screen shots) **The LME shall provide Enrollees with …..** • Provide a detailed plan that describes how enrollees are educated about mental health, substance abuse, and Innovations benefits and services. Include any evidence of education for enrollees on emergency services. • Provide a copy of your managed care and Innovations educational materials for recipients including written materials, presentations and sample screen shots of your

DMA contract section Reference #	Clinical Operations
	website. • Describe how the website ensures ease of use by enrollees such as consumer friendly language and ADA compatibility. • Provide evidence of consumer and family involvement in the development/review of these resources.
6.13 6.17	***Care Management-Mental Health/Substance Abuse Services*** [Limit to 10 pages for both MH/SA and I/DD (exclusive of the organizational chart and job descriptions)] **The LME shall have a care management (CM) program that is staffed by licensed professionals and is sufficient to meet the care management needs of the enrolled population.** • Describe how the care management department will be organized. Provide a detailed organization chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing care management functions. Identify both current positions (note if filled or vacant) and planned future positions. • Submit the proposed job descriptions for these positions. • Describe how the LME will identify individuals with (MH/SA) special health care needs to ensure that all needs are addressed through clinically indicated services. Describe the process by which the LME will ensure each enrollee with special health care needs receives treatment plan development by the appropriate professional. • Describe the LME's current efforts to assist consumers in overcoming barriers to services. Specifically address transportation, interpretation and coordination with community resources. Describe how these issues are addressed in staff training. ▪ Describe the role of the LME Medical Director in working with the Care Management department. o Describe the following care management processes. Address how the LME: ▪ Performs telephonic assessment and crisis intervention 24/7. ▪ Determines which behavioral health services are appropriate for the enrollee. ▪ Coordinates and monitors hospital and institutional admissions and discharges. ▪ Ensures the coordination of care with each enrollee's CCNC physician/health home. ▪ Provides follow-up to any current or new enrollee who receives crisis services. ***Care Management-Innovations/I/DD Services*** **The LME shall have a care management (CM) program that is staffed by I/DD qualified professionals and is sufficient to meet the care management needs of the enrolled population.** • Describe how the care management department for I/DD will be organized. Provide a

DMA contract section Reference #	Clinical Operations
	detailed organization chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing care management functions. Identify both current positions (note if filled or vacant) and planned future positions. • Describe the role of the I/DD Clinical Director in working with Care Management department. • Submit the proposed job descriptions for these positions. • Describe how the Care Management department will function separately and independently from the I/DD Utilization Management Department. • Describe how the LME will identify individuals with I/DD special health care needs to ensure that all needs are addressed through clinically indicated services. Describe the process by which the LME will ensure each enrollee with special health care needs receives treatment plan development by the appropriate professional. • Describe the process by which the LME will ensure that each recipients enrolled in Innovations and on the waiting list receives a Supports Intensity Scale (SIS) evaluation. • Describe the care management process for assisting enrollees in understanding and choosing the Community Guide service under the Innovations program. • Describe the process for education enrollees on the self direction model in the Innovations waiver. • Describe the following care management processes. Address how the LME: • Determines appropriate services for individuals with I/DD and co-occurring mental health and substance abuse issues • Ensures the coordination of care with each enrollee with I/DD's CCNC physician/health home. • Provider follow-up to any current or new enrollee with I/DD who received crisis services.
7.4	***Utilization Management*** [Limit to 10 pages for both MH/SA and I/DD (exclusive of the organizational chart and job descriptions)] **The LME shall have a utilization management (UM) program that is staffed by licensed professionals and I/DD qualified professionals and is sufficient to meet the needs of the enrolled population.** • Describe how the utilization management department will be organized. Provide a detailed organization chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing utilization management functions. Identify both current positions (note if filled or vacant) and planned future positions. • Submit the proposed job descriptions for these positions. *Utilization Management for Mental Health/Substance Abuse Services* • Describe how the LME will conduct the MH/SA utilization management program. Address the following issues: ▪

DMA contract section Reference #	Clinical Operations
	▪ Describe the utilization management workflow and processes for authorization and denials of care, including the qualifications of the professionals that can deny care. ▪ Describe how the LME will use data and clinical decision support information systems to support utilization management activities. Specify the types of data used. ▪ Describe the methodology for identifying over- and under-utilization of services. ▪ Describe how the LME defines and identifies high-risk and high-cost mental health and substance abuse recipients. ▪ Describe how the LME will obtain clinical advisory input from licensed mental health and substance use treatment professionals in the review of practice guidelines utilized for authorization of services. ▪ Describe the role of the LME Medical Director in working with the MH/SA Utilization Management section.. • Describe the LME's clinical guidelines for medical necessity criteria and level of care determination guidelines. Address the following: ▪ List the source of the criteria/guidelines with which the LME has experience and indicate the LME's experience in utilizing guidelines. ▪ Describe the training provided to utilization management staff and , physician advisors regarding the application of the criteria/guidelines in managing care. Include a plan for determining inter-rater reliability of medical necessity criteria application. ▪ Describe the process for assuring the criteria/guidelines are properly and consistently applied in the utilization review process. *<u>Utilization Management for Innovations/I/DD services</u>* • Describe how the LME will conduct the utilization management program for recipients with I/DD. Address the following issues: ▪ Describe the utilization management workflow and processes for authorization and denials of care, including the qualifications of the professionals that can deny care. ▪ Describe how the LME will use data and clinical decision support information systems to support utilization management activities. Specify the types of data used. ▪ Describe the methodology for identifying over- and under-utilization of services. ▪ Describe how the LME defines and identifies high-risk and high-cost developmental disabilities recipients. ▪ Describe how the LME will obtain clinical advisory input from licensed and/or qualified I/DD professionals in the review of practice guidelines utilized for authorization of services. ▪ Describe the role of the LME Medical Director in working with the I/DD Utilization Management section. • Describe the LME's clinical guidelines for I/DD medical necessity criteria and level of care determination guidelines. Address the following:

DMA contract section Reference #	Clinical Operations
	▪ List the source of the criteria/guidelines with which the LME has experience and indicate the LME's experience in utilizing guidelines. ▪ Describe the training provided to utilization management staff and , physician advisors regarding the application of the criteria/guidelines in managing care. Include a plan for determining inter-rater reliability of medical necessity criteria application. ▪ Describe the process for assuring the criteria/guidelines are properly and consistently applied in the utilization review process.
1.4-1.7 7. 7.1 Attachment M Attachment N	***Quality Assurance and Quality Improvement (Quality Management)*** (Limit 8 pages exclusive of organizational chart and job descriptions) **The LME shall provide a quality assurance and improvement program that supports increased access to services, improved outcomes and efficiency.** **Internal Quality Assurance/Performance Improvement Program:** • Describe how the LME ensures quality across all aspects of its internal operations and service area through the use of the CMS Quality Framework model.[1] Specifically, describe how the LME will implement the four components of the model as listed below. Design: How will the LME structure roles, relations, and policies and procedures to support quality internally and in its relations with providers and consumers? • Describe how the quality assurance and quality improvement will be organized. Provide a detailed organization chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing customer service functions. Identify both current positions (note if filled or vacant) and planned future positions. • Submit the proposed job descriptions for these positions. • Describe the essential elements of the LME's Quality Management Plan and how the applicant will assure that the plan is a dynamic document that focuses on continuous quality improvement activities. Include: ▪ Service delivery, administrative and clinical processes and functions to be addressed. ▪ Committee(s) structure that evidences integration of functions, responsibility and membership. ▪ Necessary data sources. ▪ Proposed outcome measures and instruments. ▪ Monitoring activities (e.g., surveys, audits, studies, profiling, etc.). ▪ Feedback loops. ▪ QM program workflow, including how the QM Committee(s) structure coordinates with the utilization management program and client rights oversight. Discovery: How will the LME monitor internal and external operations at the

[1] http://www.cms.gov/MedicaidCHIPQualPrac/07_Tools_Tips_and_Protocols.asp

DMA contract section Reference #	Clinical Operations
	individual and aggregate level to ensure effective management and a high quality service delivery system? • Describe how the LME monitors and conducts QA on a system-wide and individual case basis. • Describe how the QM program monitors, tracks and reports on applicable performance measures, performance guarantees and incentives. • Describe how the LME uses member and provider feedback (including the annual customer service satisfaction survey and complaints) and/or provider profiling to identify problems and improve service delivery. Remediation: How will the LME identify and address quality issues in its internal operations, its service provider agencies and its overall service delivery system? • Describe the method the LME will utilize to prevent, identify, and correct quality issues with contracted providers, including the role of QM in relation to provider network management. Improvement: How will the LME identify areas for improvement and implement and evaluate improvement initiatives? • Describe how the QM program will identify and prioritize areas for improvement • Describe how the QM program will utilize data to support quality improvement. Describe how the QM program will plan for, implement and evaluate performance improvement initiatives.
7.5 Attachment O	***Enrollee Grievances and Appeals*** (Limit 2 pages exclusive of organizational chart, job descriptions and reports) • Describe how the Enrollee Grievances and Appeals Unit will be organized. Provide a detailed organization chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing customer service functions. Identify both current positions (note if filled or vacant) and planned future positions. • Submit the proposed job descriptions for these positions. • Recognizing that the LME must provide separate systems for Medicaid and state grievances, for each of the most recent two calendar years, submit reports that identify: • The number and types of grievances received from consumers. • The number and types of grievances resolved within thirty days. • Rank in order from the greatest to least, the three most common types of grievances received regarding your contracted providers. • Describe the orientation and education that will be given to the LME's staff that interact with enrollees and providers regarding the recognition and processing of enrollee grievances and Medicaid appeals. • Submit within the policies and procedures manual the process for ensuring decision makers about grievances and appeals have not been involved in previous levels of review of decision making. • Submit within the policy and procedures manual a description of the assistance that

DMA contract section Reference #	Clinical Operations
	will be provided to enrollees in completing the procedural steps in the complaints and grievance system. • Submit the consumer education materials that explain Medicaid appeals and the grievance systems.
6.8 6.18 7.6 7.7 7.8	***Provider Network Management*** (Limit 8 pages exclusive of organization chart, provider lists, and sample reports) **The LME shall provide a network management program that supports the needs of enrollees and includes the following functions: Provider relations, contracting, credentialing, development, profiling and training. The LME shall have a provider manual that outlines network participation requirements.** • Describe how the provider network management section will be organized. Provide a detailed organization chart that identifies the number of FTEs, titles of each position and supervisory relationships of staff providing customer service functions. Identify both current positions (note if filled or vacant) and planned future positions. • Submit the proposed job descriptions for these positions. • Provide evidence that staff is representative of the population's ethnic and racial makeup according to the latest US Census Bureau data. • Describe the LME's plan in implementing cultural competency awareness and plan for the Provider Network to meet the demographic needs of the community population. • Describe the LME's continuum of crisis services. • Describe how the LME ensures choice of at least two providers for each service, noting approved exceptions for specialties. • Provide a listing and brief description of contracted culturally and linguistically appropriate services that address the needs of the diverse populations residing in the LME's service area. • Provide a listing and brief description of the contracted evidence based services and promising practices available in the LME's service area. • Provide the LME's most recent gaps analysis and the LME's proposed strategies to develop the network to close the gaps. • Describe the specific strategies the LME has used and will use to recruit and retain providers to assure the network will meet the needs of a diverse population for culturally appropriate care including enrollees with limited English proficiency. • Provide a description of how the LME will monitor the network's adequacy and sufficiency, including performance measures and evaluation methodologies. • Describe the transition process from an open provider network under the current Medicaid funded system to a closed Provider Network and issuing new provider contracts as a PIHP for Medicaid providers. • Describe your transition plan for consumers whose providers of record choose not to participate in the network. • Describe your plan for developing Innovations services capacity. • Describe how the LME will develop a network of Community Guide providers. • Describe how the LME will develop a network to support Consumer Self-Direction (as

DMA contract section Reference #	Clinical Operations
	specific in the Innovations waiver).
6.5 6.6	**Appointment Availability:** • Describe how the LME will ensure that enrollee appointment access standards are met, including two (2) hours if need is emergent, 48 hours if need is urgent, and 14 calendar days if need is routine. • State separately for each of the most recent two (2) calendar years, the average number of days from the date of receipt of a request for an eligibility determination to the first appointment for a member. • Describe how the LME will address access for individuals who require services when they are outside the LME's catchment area (e.g., while traveling in North Carolina or when residing in a group home outside the LME's catchment area). **Appointment Wait Time:** • Describe how the LME ensures that providers meet the requirements regarding wait times for scheduled enrollee appointments, walk-ins, and emergences as specified in the DMA Contract. • Provide a sample report for LME appointment wait times.

Administrative Operations

DMA contract section reference #	Administrative Operations
	Disclosure of Information on Ownership and Control • Submit a list of current members and terms of the Board of Directors. • Submit a list of current members and terms of the local Consumer and Family Advisory Committee.
	Disclosure of Information on Business Transactions (Limit to 4 pages exclusive of disclosures) • Submit any disclosure as described in Attachment R of the DMA Contract. • Describe your internal controls and systems to account for contract related and non-contract related revenues and expenses and to prevent and detect fraud.

6.9	***Facilities and Organization***
	(Limit to 5 pages)
	
	The LME shall have facilities and an organizational structure that is sufficient to support the operations of the waiver program.
	
	• Identify the main place of business of the LME-PIHP where the majority of operations described in the RFA will be provided. If there are multiple sites, describe the functions at each site and the approach to coordination of requirements specified in the RFA.
	• Submit a functional organizational chart to demonstrate that the LME meets the criteria for the clinical, administrative and financial management positions required to perform the functions of the contract as specified below:
	  • One full time medical director holding an unencumbered North Carolina medical license and who is board certified in psychiatry.
	  • One full time contract manager with a minimum of at least seven years of management experience preferably in human service that will act as the primary contact to DHHS.
	  • One full time director of management information systems with a minimum of five years experience in data management and IT project management in health care.
	  • One full time utilization management director that is a Master's level clinician licensed in North Carolina and has a minimum of five years utilization review and management experience in mental health, developmental disabilities and substance abuse care.

DMA contract section reference #	Administrative Operations
	• One full time Clinical Director for Innovations (I/DD) services that has a minimum of seven years of utilization review and care management experience in I/DD care. • One full time quality management director that is preferably a licensed clinician with at least five years recent quality management experience and two years managed care experience or experience in mental health, developmental disabilities and substance abuse care. • One full time customer services director with at least 5 years combined customer service, clinical and management experience. • One full time provider network director that is a licensed clinician that has at least five years combined clinical, network operations, provider relations and management experience. • One full time finance director with at least 7 years experience managing progressively larger budgets • For each position, attach current resume with details sufficient to evidence education and experience pertinent to the position. • For staff not yet hired, attach a job description with minimum requirements of the position. • All key positions essential for activities related to the development of the managed care organization infrastructure and implementation of activities in preparation for the final readiness must be hired and in training no later than 90 prior to the start date of managed care operations. This planning must be evident in this and other sections of the application as well as the implementation plan. • Describe the LME's plan to hire or otherwise include consumers and family members in daily operations.
7.9	***Management Information System*** (Limit to 5 pages) • Describe the LME's management information system (MIS). Explain the LME's current plan to implement a new MIS or update a current MIS. Detail necessary upgrades and timelines for upgrades and testing; include list of contracted vendors who will be going upgrades and testing. • Describe the LME's management information system and submit documentation to support items listed in section 7.9 of the contract pertaining to the required Health Information System. Recommended items include system flow charts, policies and procedures, reports, training manuals and any other information that demonstrates the LME's capabilities. • Describe the LME's automated management information system and submit documentation that it is capable of performing all the activity, interfacing and reporting requirements of a managed care organization utilizing electronic data interchange using HIPAA transactions, including claims adjudication, third party coordination, eligibility maintenance, membership reconciliation, provider and fee schedule maintenance, capitation payment reconciliation, financial reporting and encounter data creation and

DMA contract section reference #	Administrative Operations
	submission, provider access to check the status of their service authorization requests, claims submission and claims payment status. • Describe the LME's ability to work with DHHS to test and implement a health information system in conjunction with the Provider Network for the collection and reporting of consumer health record information. • Include as evidence items such as system flow charts, policies and procedures, reports, training manuals, hardware and software inventories, long range strategic IT plan and any other information that demonstrates the LME's capabilities. • Describe the LME's migration plan and progress in adopting the ANSI 5010 (deadline January 1, 2012) and ICD-10 (deadline October 1, 2013).
Section 8 8.1 8.3	***Records*** (Limit to 5 pages) **The LME shall assure that the standards for the establishment, maintenance and retention/disposition of clinical care records by the LME and network providers are met according to the Records Management and Documentation Manual (APSM 45-2) and the Records Retention and Disposition Schedule for State and Area Facilities (APSM 10-3) and any ensuing updates thereof. The LME shall maintain all LME Administrative Records and other service management records in accordance with APSM 45-2 and APSM 10-3 and the terms of the DMA Contract and with all specifications for record keeping established by DMA for purposes of audit and program management. Where there are inconsistencies, the more stringent standard applies.** **Clinical Records:** • Describe how the LME collects and maintains information for the managed care organization's Service Management Records for Medicaid-funded services. • Prepare for an on site review of LME records that demonstrate the process of authorizations and how medical necessity is documented. • Describe how the LME meets the requirement to maintain Network Provider Medical Records according to APSM 45-2 and APSM 10-3. • Describe how the LME assures that providers maintain records in accordance with State policies including those providers who go out of business. • Describe how the LME assists providers in maintaining adequate consumer records.
9.2	***Encounter Data and Claims*** (Limit to 3 pages) **The LME shall report encounters for all services provided.** • The LME shall provide as documentation a pictorial system flow of the process for creating encounter data. LME should include policies and procedures, reports and user documentation that are used in the encounter data process. • Describe and provide supporting documentation for creating and transmitting

DMA contract section reference #	Administrative Operations
	encounter data to DMA using the current HIPAA compliant 837 transaction format via secure FTP (File Transfer Protocol) • Describe and provide supporting documentation for reconciling any and all errors found during encounter claim processing by DMA's fiscal agent. • Submit written policies and procedures that have been formally adopted by the LME for ensuing system recoverability both for LME information systems and for those of subcontractors. • Submit written policies and procedures that have been formally adopted by the LME for providing primary and backup system for electronic submission of data to DMA and DMH/DD/SAS. • Submit written policies and procedures that have been formally adopted by the LME that address how LME information systems are used for utilization review and resource management. • Provide a description of internal controls regarding fraud and abuse. • Provide copies of submission reports that are generated during the encounter submission process, both from subcontractors to the LME and from the LME to DMA and DMH/DD/SAS. • Provide copies of all enrollment and eligibility reports that demonstrate accurate receipt, processing and reconciliation.
1.10 9.3 9.6 Attachment W	***Financial Reporting Requirements*** (Limit to 5 pages excluding the financial statements) **The LME shall submit financial reports that are timely, accurate, and complete.** • Provide a description of the LME's accounting and information system and the LME's ability to implement changes in reporting requirements or provide ad-hoc data requests as required by DMA. • Provide a copy of the LME's most current annual audit. • Using most recent annual audit provide the applying LME's Current Ratio = current assets / current liabilities. • Using most recent annual audit provide the applying LME's Defensive Interval = (cash + cash equivalents) / ((operating expense - non-cash expense) / (period being measured in days)). • Describe the LME's process for certifying financial records submitted as reports.
9.4 Attachment M	***Clinical Reporting Requirements*** (Limit to 3 pages) **The LME shall have a clinical reporting system that includes reports on utilization data, on performance measurements and on performance improvement projects sufficient to manage and improve services to enrollees.** • Describe how the management information system used by the LME creates clinical

DMA contract section reference #	Administrative Operations
	reports and explain the process for making changes to meet new reporting requirements. • Describe the LME's consumer outcomes data collection, tracking and utilization.
9.5	***Fraud and Abuse*** (Limit to 3 pages) **The LME shall adopt and implement policies and procedures to guard against fraud and abuse**. • Describe the process for identifying potential fraud and abuse.
Section 11 11.1	***Subcontracts*** (Limit to 3 pages) **The LME may enter into subcontracts for the performance of its administrative functions and for the provision of covered services to enrollees.** Describe and provide transition plan for implementation of subcontractor function and give a detailed description of the scope of work, along with background reference checks of work performance and credibility of performance.
11.2	***Timeliness of Provider Payments*** (Limit to 5 pages) **The LME shall have evidence of the LME's history of prompt payment to providers.** • Describe the LME's provider payment history for the past three years.
Section 1.9 8.2	***Financial Management/Monitoring*** (Limit to 6 pages) **The LME shall have internal controls and systems in place to ensure that all Title XIX Medicaid revenue and expenditures are accounted for separately from other funding sources.** • Provide a description of the LME's internal controls and systems in place to ensure that all Title XIX Medicaid revenue and expenditures are accounted for separately from other funding sources. • Provide a description of the LME's process for calculating Incurred But Not Reported (IBNR). • Provide a description of the LME's process to monitor and track monthly capitation payments to ensure service delivery can be provided throughout the contract year. Within this description, describe the LME's budgeting process and methods to track actual expenditures against budgets. Describe the process as it relates to both Title

DMA contract section reference #	Administrative Operations
	XIX Medicaid and other funding sources. • Provide a description of the LME's process in place to demonstrate that all third-party resources are identified, pursued, and recorded. All funds recovered by the LME from third-party resources shall be treated as income. • Provide a description of how payments to providers by the LME shall be made on a timely basis, as required by section 11.2 of the contract. • Provide a plan as to how the LME will set up and manage the risk reserve.
Section 2	***LME-MCO Organizational Arrangements*** (Limit to 2 pages exclusive of formal agreements) See the discussion in the Scope of Work and submit the following: • Definition of the geographical area and the business relationships formulated to act as a single managed care organization (MCO). • Attached evidence of business affiliations and all formal contracting agreements, including subcontracting arrangements. • Describe and submit evidence of all community stakeholder engagement (consumers and families, CFAC, provider network, community and county agencies) in submitting this RFA application to the State. • Describe and demonstrate evidence of future and ongoing efforts to strengthen the collaborative partnerships with the LME operating a PIHP.
Section 4	***Enrollment and Disenrollment*** (Limit to 1 page) **The LME operating a PIHP shall have policies and procedures for facilitating information exchange with the local department of social services regarding enrollee participation in the Innovations Waiver 1915 (c).** • Discuss the policies and procedures in place to facilitate the exchange of information with the local departments of social services regarding enrollment and disenrollment and approvals for participation in the North Carolina Innovations, Comprehensive and Supports waivers. • Describe development of relationships with local county departments of social services regarding enrollees.

Implementation Requirements

(Limit to 15 pages)

This section of the application provides evidence that the applying LME foresees the organization and coordination of tasks and resources necessary for implementing the administrative and clinical functions within available financial resources and within the time frame specified in this RFA. Threads of these plans must be evident in each section addressed in the scope of work. For purposes of the implementation and financial plans, use January 1, 2013 as the start date.

The LME applying to operate a PIHP shall submit the following to meet the requirements of this part of the application.

1. An **Implementation Plan** that demonstrates the LME's capacity to fully implement the administrative and clinical functions and requirements of a managed care organization as specified in the RFA within the required time frame.

   The template shown in attachment D identifies generic tasks necessary for the implementation of each function and benchmarks for any subcontracting or contractual agreements. These generic tasks and benchmarks must be included in the LME's implementation plan. Using the template, provide for each of the administrative and clinical functional areas described in the Scope of Work in sufficient detail to clearly articulate tasks, time frames, staffing needs and expected results for each of the RFA requirements identified. Additional tasks and subsets of tasks may be added. In particular, ensure that the implementation plan includes:

   - Hiring of additional staff, with timeframes sufficient to provide training and accomplish the tasks of implementation.
   - The methodology for determining the staffing patterns/numbers required by the various functions within the scope of work.
   - The means used to ensure the completion and successful operation of each function.
   - Two on-site readiness reviews: 180 days and 45 days prior to start date.

2. A **Financial Plan** that demonstrates the LME's capability to utilize existing and any additional resources to cover the total costs of implementation of all requirements specified in the RFA within the required time frame until receipt of the monthly PMPM. The plan shall include the source and allocation of funds and expenditures for setting up all managed care functions such as paying for all subcontracts, hiring and training of staff, and establishing the provider network.

3. A **Policy and Procedure Manual** for operating the PIHP (one copy). Note that the policy and procedural manual that will support the activities of a LME operating a PIHP will be used as reference during the desk review and will be reviewed in full onsite.

After the award is made, the LME shall expand the Implementation Plan and the Financial Plan into a detailed project plan no later than thirty (30) days from award of contract. This detailed project plan must be approved by DMA and DMHDDSAS. The successful LME must participate in assigned DHHS Intradepartmental Monitoring Team (IMT) meetings and submit weekly progress notes on administrative, clinical and financial implementation.

Pending Lawsuits and Judgments

(Limit 2 pages)

- Submit a statement that there have been no legal actions taken against the LME applying to operate a PIHP in the past two (2) years and there are no judgments or other legal actions pending;

OR,

- If any legal action has been taken, or is pending, provide an explanation.

If selected, and if the LME encounters a lawsuit or investigation, or if judgment action is taken against the selected LME(s) during the course of implementation, the LME will notify DMA and DMHDDSAS immediately.

CONTENT OF THE APPLICATION

Assemble the application ensuring that the following information is included in the following order.

1. Signed Transmittal Letter
2. Application Face Sheet (see appendix B)
3. Table of Contents
4. Minimum Requirements Packet including the Checklist (appendix C) plus the Evidence organized in the order as specified in the Checklist.
5. Application Narrative (must follow the order in the Scope of Work as shown on pages 15 through 27)
6. Implementation Plan (appendix D)
7. Financial Plan
8. Policy and Procedure Manual for PIHP operations (1 copy)
9. Appendices: extra documents required to support the application narrative

Number each page consecutively beginning with the Application Face Sheet. Provide one original and twelve (12) copies of the application. Place each copy in a notebook with separate tabs according to the table of contents.

In addition, submit only the requested number of copies of specific items (such as the annual audit and financial statements) as attachments to the application.

Note that this RFA and the application will become part of the DMA Contract and the DMH/DD/SAS Contract. These contracts will be finalized prior to signature.

Minimum Requirements Packet (Pass/Fail)

Complete and submit the Minimum Requirements Checklist as provided in appendix C to confirm that the LME applying to operate a PIHP meets the minimum requirements of this RFA. Provide all the requested documents outlined in the minimum requirements in one packet entitled Minimum Requirements including the Checklist and all evidence of compliance. The checklist includes:

- First column - Requirements: The minimum organizational requirements that must be met by any potential LME for the administration of the 1915(b)/(c) waivers.

- Second column – Reference: The documentation in the DMA contract, the DHHS waiver technical amendment application submitted to CMS, or in this RFA of the details of the requirement listed.

- Third column – Page Numbers: The page numbers of the LME's application that addresses the requirement. For each requirement, insert required documentation in the Minimum Requirements Packet. If other documents are referenced, provide the title(s) of the corresponding document(s) that address(es) the requirement and applicable page number(s) of the Application Narrative.

- Last column – Fully Met: A check mark here verifies the requirement is FULLY met by the LME.

EVALUATION OF APPLICATIONS

In accordance with RFA requirements, the award will be made to one or more LMEs whose application(s) are determined to be the most advantageous to the State in managing and administering the mental health, developmental disabilities and substance abuse programs and services as defined in the Scope of Work, the DMA Contract and DMH/DD/SAS Contract referenced in this RFA. Capitation rates shall not be a factor in the proposal evaluation as DHHS will negotiate the capitation rates with the successful LME based upon the population served and the requirements specified in the Scope of Work. The objective of the RFA is to select one or more LMEs to operate a PIHP that brings:

1. A proven track record with demonstrated success in operating as a local management entity (LME) as defined in N.C.G.S. 122C-116.

2. Demonstrated capacity to operate a managed care program as exemplified by:
    - A cohesive management structure that meets the requirements to contract with the State.
    - A flexible, responsive customer services approach that is highly ingrained in the organization and promotes 24-hour access to services.
    - Access to industry standard tools, technology, and expertise in mental health, developmental disabilities and substance abuse services.
    - A care management/utilization management (UM) program that is person-centered, emphasizes the principles of recovery and resilience and self-determination, and relies on a state of the art UM protocols and clinical practice guidelines.
    - A well developed quality management program that has sufficient clinical and technical leadership and data management capabilities to monitor and improve access, quality and efficiency of care.
    - A provider network management program that facilitates the development, support and monitoring of network providers for the delivery of mental health, developmental disabilities and substance abuse services provided to children, youth, families and adults.
    - Experience and demonstrated success in implementing program innovations that result in improved administrative and clinical outcomes, such as increased access to care by traditionally underserved populations of all ages, improved community tenure, mental health/developmental disabilities/substance abuse-physical health integration, and integrated assessment and service delivery for both co-occurring mental illness and substance use disorders and co-occurring mental illness and developmental disabilities.
    - Human resource and management support necessary to effectively recruit and retain clinical and administrative qualified professional staff.
    - A solvent and financially viable organization that has sufficient financial and administrative resources to implement and operate managed care functions specified in this RFA.
    - An automated management information system that is capable of performing all the activity, interfacing and reporting requirements utilizing electronic data interchange using HIPAA transactions.

3. Demonstrated capacity and a proven approach to managing systems of care that:
    - Rely on innovative approaches to address the diversity and cultures of the population served, including, at a minimum, contracts with culturally competent providers.
    - Identify and implement the preferences of individuals and families in the design of services and supports through development and utilization of person-centered planning.
    - Facilitate the development of consumer-operated programs and use of peer support, including consumer/family team approaches.

- Facilitate the development and utilization of natural supports.
- Facilitate the use of self-management and relapse prevention skills, support stable housing, and address the development and maintenance of healthy social networks and skills, employment, school performance or retirement activities.

4. Demonstrated capacity to implement the requirements specified in this RFA through a well-designed and detailed implementation plan that clearly articulates tasks, time frames, and expected results.

Initial Review

The State will review all applications submitted by the deadline specified in the RFA for format and completeness. If the applicant meets the formatting and minimum requirements listed herein, the State will continue to evaluate the application. The State at its sole discretion may request clarification of information throughout the proposal evaluation process.

Application Evaluation

The State shall conduct a comprehensive, confidential, fair and impartial evaluation of the applications received in response to this request. The State reserves the right to reject any and all applications.

An Evaluation Committee will evaluate and numerically score each application that the State has determined to be responsive to the requirements of this RFA. The Evaluation Committee will be responsible for the entire evaluation process, including reference checks of vendors that the LME may choose for subcontracting one or more functions. The State reserves the right to determine the composition of the committee and to designate subject matter experts to assist in the process. Other designated staff of DHHS may act as observers during the evaluation and selection process.

The Evaluation Committee will conduct a desk review of each application and recommend one or more LME(s) as finalist(s) whose application is deemed to be in the best interest of the State. The State will schedule an on-site review of the finalist(s). The State will provide finalist LME(s) at least one (1) week notice in advance of the site visit. The LME(s) shall assure that all key personnel and any individual(s) who will function as significant contact person(s) in performance of the proposed program will be available during the site visit.

Final scoring will include the findings of the site visit and the desk review. The Evaluation Committee will make final recommendations to the DHHS leadership for final selection.

Minimum Requirements

In the proposal evaluation phase, the Evaluation Committee will rate the applications submitted in response to this RFA based on the following criteria outlined in the next section and the weight assigned each criterion. An LME must meet the Minimum Requirements as specified above to be included in this part of this evaluation phase.

Evaluation Criteria

The Evaluation Committee will evaluate the LME's strengths, capabilities, and experience including corporate background, past and current projects, financial soundness, and performance history. The State

shall conduct reference checks of vendors to verify the accuracy of submitted materials and to ascertain the quality of past performance. The State reserves the right to pursue any references that may assist in completing the application evaluation process. Submission of the application establishes the LME's agreement for the State to make any contacts it deems necessary to confirm the organization's experience and performance.

Applications will be evaluated based upon the evaluation criteria and the associated scoring listed in table 4.

Table 4. Evaluation Criteria and Scoring

Criteria	Score
1. Meets Minimum Requirements and Financial Status and Viability	Pass/fail
2. **Clinical Operations** • Customer service • Care Management/Utilization management • Quality Assurance and Quality Improvement • Provider Network Management	40%
3. **Administrative Operations** • Financial Management • Disclosure of Information on Ownership and Control • Disclosure of Information on Business Transactions • Facilities and Organization • Information Technology and Reporting • Enrollment and Disenrollment • Records • Encounter Data • Reporting Requirements • Fraud and Abuse • Timeliness of Provider Payments	40%
4. **Implementation plan** • Tasks • Timelines • Expected results • Transition for implementation of subcontracted functions • Includes review of Policy and Procedures Manual	20%

THE PROCUREMENT PROCESS

The following is a general description of the process by which one or more LME will be selected to complete the goals or objectives of this RFA.

Written questions concerning the RFA specifications will be received until 5:00 p.m. on Friday, April 15, 2011 as specified on the cover sheet of this RFA. Send questions in writing via email to: RFA.Medicaidwaiver@dhhs.nc.gov. *A summary of all questions received by email and their answers will be posted by 5:00 p.m. on Friday, April 22, 2011 on the websites for DMA at:* *http://www.ncdhhs.gov/dma/lme/MHWaiver.htm* *and for DMH/DD/SAS at:* *http://www.ncdhhs.gov/mhddsas/waiver/index.htm*

Applications in one original and twelve (12) hard paper copies must be received from each applying LME. The original Application Face Sheet (see appendix B) must be signed and dated by an official authorized to bind the LME.

All applications must be received by the funding agency not later than the date and time specified on the cover sheet of the RFA. Faxed applications will not be accepted.

The date and time the applications are received from each responding LME will be logged in.

At their option, the Evaluation Committee may request additional information from any or all applicants for the purpose of clarification or to amplify the materials presented in any part of the application. However, LMEs are cautioned that the evaluators are not required to request clarification: therefore, all applications should be complete and reflect the most favorable terms available from the agency or organization.

Applications will be evaluated according to completeness, content, experience with similar projects, ability of the agency's or organization's staff, cost, etc. The selection of one LME does not mean that the other applications lacked merit, but that, all facts considered, the selected application(s) was deemed to provide the best service to the State.

LMEs are cautioned that this is a request for applications, and the funding agency reserves the unqualified right to reject any and all applications when such rejections are deemed to be in the best interest of the funding agency.

GENERAL INFORMATION ON SUBMITTING APPLICATIONS

1. Award or Rejection

All qualified applications will be evaluated and award made to that LME whose combination of budget and service capabilities are deemed to be in the best interest of the funding agency. The funding agency reserves the unqualified right to reject any or all offers if determined to be in its best interest. Successful applicants will be notified only after the NC General Assembly passes legislation for waiver expansion., .

2. Decline to Offer

N/A

3. Cost of Application Preparation

Any cost incurred by an LME in preparing or submitting an application is the LME's sole responsibility; the funding agency will not reimburse any LME for any pre-award costs incurred.

4. Elaborate Applications

Elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired. It is preferred that all submittals meet the following requirements:

- All copies are printed double sided.
- The font used must be at least 11 point.
- All submittals and copies are printed on **recycled paper with a minimum post-consumer content of 30%** and indicate this information accordingly on the response.
- Unless absolutely necessary, all proposals and copies should **minimize or eliminate use of non-recyclable or non re-usable materials** such as plastic report covers, plastic dividers, vinyl sleeves, and GBC binding. Three ringed binders, paper clips, and staples are acceptable.
- Materials should be submitted in a format that allows for **easy removal and recycling** of paper materials.

5. Oral Explanations

The funding agency will not be bound by oral explanations or instructions given at any time during the competitive process or after awarding the contract.

6. Reference to Other Data

Only information that is received in response to this RFA will be evaluated; reference to information previously submitted will not suffice.

7. Titles

Titles and headings in this RFA and any subsequent RFA are for convenience only and shall have no binding force or effect.

8. Form of Application

Each application must be submitted on the form provided by the funding agency, and will be incorporated into the funding agency's Performance Agreement (contract).

9. Exceptions

All applications are subject to the terms and conditions outlined herein. All responses will be controlled by such terms and conditions. The attachment of other terms and condition by any agency and organization may be grounds for rejection of that agency or organization's application. Funded agencies and organizations specifically agree to the conditions set forth in the Performance Agreement (contract).

All proposals are subject to the terms and conditions outlined in the attached RFA as well as the DMA Contract and the DMH/DD/SAS Contract that accompanies this request and the 1915 b/c Medicaid Waiver applications submitted to CMS.

10. Advertising

In submitting its application, agencies and organizations agrees not to use the results therefrom or as part of any news release or commercial advertising without prior written approval of the funding agency.

11. Right to Submitted Material

All responses, inquiries, or correspondence relating to or in reference to the RFA, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the agency or organization will become the property of the funding agency when received.

12. Competitive Offer

Pursuant to the provision of G.S. 143-54, and under penalty of perjury, the signer of any application submitted in response to this RFA thereby certifies that this application has not been arrived at collusively or otherwise in violation of either Federal or North Carolina antitrust laws.

13. Agency and Organization's Representative

Each agency or organization shall submit with its application the name, address, and telephone number of the person(s) with authority to bind the agency or organization and answer questions or provide clarification concerning the application.

There must be a transmittal letter signed and dated by an official authorized to legally bind the LME. The LME shall submit with its application the name, USPS address, email address and telephone number of the person(s) with authority to bind the organization and answer questions or provide clarification concerning the proposal.

14. Subcontracting

Agencies and organizations may propose to subcontract portions of work provided that their applications clearly indicate the scope of the work to be subcontracted, and to whom. All information required about the prime grantee is also required for each proposed subcontractor.

15. Proprietary Information

Trade secrets or similar proprietary data which the agency or organization does not wish disclosed to other than personnel involved in the evaluation will be kept confidential to the extent permitted by NCAC TO1: 05B.1501 and G.S. 132-1.3 if identified as follows: Each page shall be identified in boldface at the top and bottom as "CONFIDENTIAL." Any section of the application that is to remain confidential shall also be so marked in boldface on the title page of that section.

16. Participation Encouraged

N/A

17. Contract

DMA and DMH/DD/SAS will issue contracts to the selected LME(s) that will include the RFA and the LME's application.

The contract may include assurances the successful applicant would be required to execute when signing the contract.

It will also include a Notice of Certain Reporting and Audit Requirements Form that addresses compliance with all rules and reporting requirements established by statute or administrative rule.

For all contracts that require a conflict of interest policy (required for all Private not for profit agency), the agency or organization must complete a Notarized Conflict of Interest Policy Statement and submit a copy of their conflict of interest policy. The Agency or organization can adopt page 2 as their conflict of interest policy or attach their current adopted policy.

Agencies or organizations receiving Federal funds would be required to execute a certification regarding Lobbying and Debarment, and if applicable a Drug Free Workplace Requirements and/or Environmental Tobacco Smoke assurance.

18. Liability

Neither the State of North Carolina, nor its employees, shall be responsible for any liability claims against the LME.

Appendix A: General Terms and Conditions

Relationships of the Parties

Independent Contractor: The Contractor is and shall be deemed to be an independent contractor in the performance of this contract and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Contractor represents that it has, or shall secure at its own expense, all personnel required in performing the services under this agreement. Such employees shall not be employees of, or have any individual contractual relationship with, the Division.

Subcontracting: The Contractor shall not subcontract any of the work contemplated under this contract without prior written approval from the Division. Any approved subcontract shall be subject to all conditions of this contract. Only the subcontractors specified in the contract documents are to be considered approved upon award of the contract. The Division shall not be obligated to pay for any work performed by any unapproved subcontractor. The Contractor shall be responsible for the performance of all of its subcontractors.

Assignment: No assignment of the Contractor's obligations or the Contractor's right to receive payment hereunder shall be permitted. However, upon written request approved by the issuing purchasing authority, the State may:

(a) Forward the Contractor's payment check(s) directly to any person or entity designated by the Contractor, or
(b) Include any person or entity designated by Contractor as a joint payee on the Contractor's payment check(s).

In no event shall such approval and action obligate the State to anyone other than the Contractor and the Contractor shall remain responsible for fulfillment of all contract obligations.

Beneficiaries: Except as herein specifically provided otherwise, this contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Division and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Division and Contractor that any such person or entity, other than the Division or the Contractor, receiving services or benefits under this contract shall be deemed an incidental beneficiary only.

Indemnity and Insurance

Indemnification: The Contractor agrees to indemnify and hold harmless the Division, the State of North Carolina, and any of their officers, agents and employees, from any claims of third parties arising out of any act or omission of the Contractor in connection with the performance of this contract.

(a) **Insurance:** During the term of the contract, the Contractor shall provide, at its sole cost and expense, commercial insurance of such types and with such terms and limits as may be reasonably associated with the contract. At a minimum, the Contractor shall provide and maintain the following coverage and limits:
   (1) **Worker's Compensation Insurance**: The Contractor shall provide and maintain worker's compensation insurance, as required by the laws of the states in which its employees work, covering all of the Contractor's employees who are engaged in any work under the contract.
   (2) **Employer's Liability Insurance:** The Contractor shall provide employer's liability insurance, with minimum limits of $500,000.00, covering all of the Contractor's employees who are engaged in any work under the contract.
   (3) **Commercial General Liability Insurance**: The Contractor shall provide commercial general liability insurance on a comprehensive broad form on an occurrence basis with a minimum combined single limit of $1,000,000.00 for each occurrence.
   (4) **Automobile Liability Insurance**: The Contractor shall provide automobile liability insurance with a combined single limit of $500,000.00 for bodily injury and property damage; a limit of $500,000.00 for uninsured/under insured motorist coverage; and a limit of $2,000.00 for medical payment coverage. The Contractor shall provide this insurance for all automobiles that are:
      (A) owned by the Contractor and used in the performance of this contract;
      (B) hired by the Contractor and used in the performance of this contract; and
      (C) owned by Contractor's employees and used in performance of this contract ("non-owned vehicle insurance"). Non-owned vehicle insurance protects employers when employees use their personal vehicles for work purposes. Non-owned vehicle insurance supplements, but does not replace, the car-owner's liability insurance.

The Contractor is not required to provide and maintain automobile liability insurance on any vehicle – owned, hired, or non-owned -- unless the vehicle is used in the performance of this contract.

(b) The insurance coverage minimums specified in subparagraph (a) are exclusive of defense costs.
(c) The Contractor understands and agrees that the insurance coverage minimums specified in subparagraph (a) are not limits, or caps, on the Contractor's liability or obligations under this contract.
(d) The Contractor may obtain a waiver of any one or more of the requirements in subparagraph (a) by demonstrating that it has insurance that provides protection that is equal to or greater than the coverage and limits specified in subparagraph (a). The Division shall be the sole judge of whether such a waiver should be granted.
(e) The Contractor may obtain a waiver of any one or more of the requirements in paragraph (a) by demonstrating that it is self-insured and that its self-insurance provides protection that is equal to or greater than the coverage and limits specified in subparagraph (a). The Division shall be the sole judge of whether such a waiver should be granted.
(f) Providing and maintaining the types and amounts of insurance or self-insurance specified in this paragraph is a material obligation of the Contractor and is of the essence of this contract.
(g) The Contractor shall only obtain insurance from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in the State of North Carolina. All such insurance shall meet all laws of the State of North Carolina.
(h) The Contractor shall comply at all times with all lawful terms and conditions of its insurance policies and all lawful requirements of its insurer.
(i) The Contractor shall require its subcontractors to comply with the requirements of this paragraph.
(j) The Contractor shall demonstrate its compliance with the requirements of this paragraph by submitting certificates of insurance to the Division before the Contractor begins work under this contract.

Default and Termination

Termination Without Cause: The Division may terminate this contract without cause by giving 30 days written notice to the Contractor.

Termination for Cause: If, through any cause, the Contractor shall fail to fulfill its obligations under this contract in a timely and proper manner, the Division shall have the right to terminate this contract by giving written notice to the Contractor and specifying the effective date thereof. In that event, all finished or unfinished deliverable items prepared by the Contractor under this contract shall, at the option of the Division, become its property and the Contractor shall be entitled to receive just and equitable compensation for any satisfactory work completed on such materials, minus any payment or compensation previously made. Notwithstanding the foregoing provision, the Contractor shall not be relieved of liability to the Division for damages sustained by the Division by virtue of the Contractor's breach of this agreement, and the Division may withhold any payment due the Contractor for the purpose of setoff until such time as the exact amount of damages due the Division from such breach can be determined. In case of default by the Contractor, without limiting any other remedies for breach available to it, the Division may procure the contract services from other sources and hold the Contractor responsible for any excess cost occasioned thereby. The filing of a petition for bankruptcy by the Contractor shall be an act of default under this contract.

Waiver of Default: Waiver by the Division of any default or breach in compliance with the terms of this contract by the Contractor shall not be deemed a waiver of any subsequent default or breach and shall not be construed to be modification of the terms of this contract unless stated to be such in writing, signed by an authorized representative of the Department and the Contractor and attached to the contract.

Availability of Funds: The parties to this contract agree and understand that the payment of the sums specified in this contract is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds for this purpose to the Division.

Force Majeure: Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations by any act of war, hostile foreign action, nuclear explosion, riot, strikes, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

Survival of Promises: All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

Intellectual Property Rights

Copyrights and Ownership of Deliverables: All deliverable items produced pursuant to this contract are the exclusive property of the Division. The Contractor shall not assert a claim of copyright or other property interest in such deliverables.

Federal Intellectual Property Bankruptcy Protection Act: The Parties agree that the Division shall be entitled to all rights and benefits of the Federal Intellectual Property Bankruptcy Protection Act, Public Law 100-506, codified at 11 U.S.C. 365 (n) and any amendments thereto.

Compliance with Applicable Laws

Compliance with Laws: The Contractor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.

Equal Employment Opportunity: The Contractor shall comply with all federal and State laws relating to equal employment opportunity.

Health Insurance Portability and Accountability Act (HIPAA): The Contractor agrees that, if the Division determines that some or all of the activities within the scope of this contract are subject to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended ("HIPAA"), or its implementing regulations, it will comply with the HIPAA requirements and will execute such agreements and practices as the Division may require to ensure compliance.

Executive Order # 24: "By Executive Order 24, issued by Governor Perdue, and N.C. G.S.§ 133-32, it is unlawful for any vendor or contractor (i.e. architect, bidder, contractor, construction manager, design professional, engineer, landlord, Applicant, seller, subcontractor, supplier, or vendor), to make gifts or to give favors to any State employee of the Governor's Cabinet Agencies (i.e., Administration, Commerce, Correction, Crime Control and Public Safety, Cultural Resources, Environment and Natural Resources, Health and Human Services, Juvenile Justice and Delinquency Prevention, Revenue, Transportation, and the Office of the Governor). This prohibition covers those vendors and contractors who have a contract with a governmental agency; or have performed under such a contract within the past year; or anticipate bidding on such a contract in the future.

For additional information regarding the specific requirements and exemptions, vendors and contractors are encouraged to review Executive Order 24 and G.S. Sec. 133-32.

Executive Order 24 also encouraged and invited other State Agencies to implement the requirements and prohibitions of the Executive Order to their agencies. Vendors and contractors should contact other State Agencies to determine if those agencies have adopted Executive Order 24."

Confidentiality

Confidentiality: Any information, data, instruments, documents, studies or reports given to or prepared or assembled by the Contractor under this agreement shall be kept as confidential and not divulged or made available to any individual or organization without the prior written approval of the Division. The Contractor acknowledges that in receiving, storing, processing or otherwise dealing with any confidential information it will safeguard and not further disclose the information except as otherwise provided in this contract.

Oversight

Access to Persons and Records: The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with General Statute 147-64.7. Additionally, as the State funding authority, the Department of Health and Human Services shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions.

Record Retention: Records shall not be destroyed, purged or disposed of without the express written consent of the Division. State basic records retention policy requires all grant records to be retained for a minimum of five years or until all audit exceptions have been resolved, whichever is longer. If the contract is subject to federal policy and regulations, record retention may be longer than five years since records must be retained for a period of three years following submission of the final Federal Financial Status Report, if applicable, or three years following the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involving this Contract has been started before expiration of the five-year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular five-year period described above, whichever is later.

Warranties and Certifications

Date and Time Warranty: The Contractor warrants that the product(s) and service(s) furnished pursuant to this contract ("product" includes, without limitation, any piece of equipment, hardware, firmware, middleware, custom or commercial software, or internal components, subroutines, and interfaces therein) that perform any date and/or time data recognition function, calculation, or sequencing will support a four digit year format and will provide accurate date/time data and leap year calculations. This warranty shall survive the termination or expiration of this contract.

Certification Regarding Collection of Taxes: G.S. 143-59.1 bars the Secretary of Administration from entering into contracts with vendors that meet one of the conditions of G.S. 105-164.8(b) and yet refuse to collect use taxes on sales of tangible personal property to purchasers in North Carolina. The conditions include: (a) maintenance of a retail establishment or office; (b) presence of representatives in the State that solicit sales or transact business on behalf of the vendor; and (c) systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. The Contractor certifies that it and all of its affiliates (if any) collect all required taxes.

Miscellaneous

Choice of Law: The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties to this contract, are governed by the laws of North Carolina. The Contractor, by signing this contract, agrees and submits, solely for matters concerning this Contract, to the exclusive jurisdiction of the courts of North Carolina and agrees, solely for such purpose, that the exclusive venue for any legal proceedings shall be Wake County, North Carolina. The place of this contract and all transactions and agreements relating to it, and their situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

Amendment: This contract may not be amended orally or by performance. Any amendment must be made in written form and executed by duly authorized representatives of the Division and the Contractor. The Purchase and Contract Divisions of the NC Department of Administration and the NC Department of Health and Human Services shall give prior approval to any amendment to a contract awarded through those offices.

Severability: In the event that a court of competent jurisdiction holds that a provision or requirement of this contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this contract shall remain in full force and effect.

Headings: The Section and Paragraph headings in these General Terms and Conditions are not material parts of the agreement and should not be used to construe the meaning thereof.

Time of the Essence: Time is of the essence in the performance of this contract.

Key Personnel: The Contractor shall not replace any of the key personnel assigned to the performance of this contract without the prior written approval of the Division. The term "key personnel" includes any and all persons identified by as such in the contract documents and any other persons subsequently identified as key personnel by the written agreement of the parties.

Care of Property: The Contractor agrees that it shall be responsible for the proper custody and care of any property furnished to it for use in connection with the performance of this contract and will reimburse the Division for loss of, or damage to, such property. At the termination of this contract, the Contractor shall contact the Division for instructions as to the disposition of such property and shall comply with these instructions.

Travel Expenses: Reimbursement to the Contractor for travel mileage, meals, lodging and other travel expenses incurred in the performance of this contract shall not exceed the rates published in the applicable State rules. International travel shall not be reimbursed under this contract.

Sales/Use Tax Refunds: If eligible, the Contractor and all subcontractors shall: (a) ask the North Carolina Department of Revenue for a refund of all sales and use taxes paid by them in the performance of this contract, pursuant to G.S. 105-164.14; and (b) exclude all refundable sales and use taxes from all reportable expenditures before the expenses are entered in their reimbursement reports.

Advertising: The Contractor shall not use the award of this contract as a part of any news release or commercial advertising.

Appendix B: Application Face Sheet

APPLICATION FACE SHEET

Legal Name of Agency: _____

Address: _____

_____

_____

(Include physical address if different from mailing address)

Telephone Number: _____

Fax Number: _____

Email Address: _____ Agency Web-address: _____

Agency Status: ( ) Non-Profit ( ) For Profit ( ) Governmental

Agency Federal Tax ID Number: _____

Agency's Financial Reporting Year (IRS Audit Cycle) _____ through _____

Name and Title of Person Authorized to sign Contracts: _____

Name of Program (s): _____

AREA TO BE SERVED: _____

The LME applying to operate a PIHP agrees to abide by all requirements contained in this RFA and the DMA Contract and the DMH/DD/SAS Contract attached to this RFA, and any subsequent changes negotiated in future contracts or as required by the Centers for Medicare and Medicaid Services.

_____ _____

LME Director **Date**

Appendix C: Minimum Requirements Checklist

Instructions: The LME applying to operate a PIHP attests to meeting the minimum requirement indicated by placing a check in the corresponding box. In the column labeled "Page #", the LME shall place the Minimum Requirements Packet page number(s) that supply the evidence required for review by DMA and DMHDDSAS.

REQUIREMENTS	**REFERENCE**	**Page Number(s)**	Ö
1. 1. The LME applying to operate a PIHP has an unduplicated minimum Medicaid eligible population of 70,000 individuals ages 3 years and older and a total population size of 300,000 (by July 2012) and a total population size of 500,000 by July 2013.	Scope of Work: Minimum Requirements, tables 2 & 3	No evidence required. The numbers in Tables 2 & 3 suffice.	
2. The LME applying to operate a PIHP does not provide State funded or Medicaid reimbursable services (i.e., totally divested of all services at the date of application submission). Submit a list of any services provided by the LME within the past three years and date(s) of divestiture. Include the name(s) of the agency(ies) to which the services were divested and a description of the bidding process. If these agencies no longer provide the services, provide an explanation.	Scope of Work: Minimum Requirements		
3. The LME applying to operate a PIHP is currently fully accredited for a minimum of three (3) years through an accrediting body approved by DHHS, AND agrees to become URAC or NCQA accredited by the end of one year of operating the PIHP. Fill in the blanks below AND include the accreditation certificate, as well as any communication with an accrediting body for applications in process for URAC or NCQA if current accreditation is not with one of those two accrediting bodies. *Accrediting Body*:_____ *Date of accreditation:* _____ If accreditation is currently in process: *Date of application:* _____ *Expected date of accreditation:*_____	Scope of Work: Minimum Requirements		
4. The LME applying to operate a PIHP has met the requirements to receive State service dollars through single stream funding.	Scope of Work: Minimum Requirements		
5. The LME applying to operate a PIHP has financial resources (fund balance or financial support from the county if a single county LME) sufficient to develop and put into operation an infrastructure to meet all requirements of the transition, implementation, and	DMA Contract, Sections 1.9 & 1.10		

REQUIREMENTS	REFERENCE	Page Number(s)	Ö
ongoing performance of all of the functions of a managed care organization, as evidenced by independent audits and other State financial records with no significant findings. Copy of the LME's independent audits for SFY2008 and for SFY2009 with findings. Submit current Ratio and Defensive Interval. Submit documentation of either: • Restricted insolvency protection risk reserve account. Describe how the account will be managed. OR • Insolvency insurance. • The LME shall submit three (3) copies of all financial statements in accordance with Generally Accepted Accounting Principals (GAAP). Materials submitted must be sufficient to indicate the organizational stability and financial strength of the LME. These reports and statements must be prepared by an independent CPA and at a minimum include a Balance Sheet, Income and Expenditures Statement, and Statement of Cash Flow. • If the LME is selected for an onsite visit, the LME shall provide to reviewers at that time evidence that the following pro forma financial statements for LME can be prepared on an accrual basis by month for the first three (3) years beginning with the first month of the proposed execution date of the DMA Contract including: ◦ A statement of monthly revenue and expenses. ◦ A monthly cash flow analysis. ◦ A balance sheet.	RFA, pp. 29, Financial Status & Viability		
6. The LME applying to operate a PIHP shall provide written letter of support from the LME Board to approve and obligate the resources required to develop the infrastructure to operate the PIHP and to assume the financial responsibility for operating the PIHP. In the case of a single county LME applying, the LME shall provide a written letter from the Board of County Commissioners to approve and obligate the resources required to develop the infrastructure to operate the PIHP and to assume the financial responsibility for operating the PIHP. • Submit a Letter of Support from the LME Board or a Single County LME – Board of County			

REQUIREMENTS	REFERENCE	Page Number(s)	Ö
Commissioners. • The letter shall specifically address the LME Board's understanding that the State shall not provide any advance funding to finance the development of the LME's infrastructure for this project and that the financial resources to do such must come from the fund balance and/or other LME resources. • The letter shall be signed by the Board chair • Minutes of the Board meeting where the action item was discussed and the vote taken shall accompany the letter.			
7. The applying LME must provide a letter of intent that is signed by all parties describing the relationship of the parties with respect to management and business functions, roles and financial arrangements within the newly proposed managed care organization (DMA contract). The letter of intent among two or more LMEs will also specify the commitment to merge or the commitment to designate the lead LME and the subcontracted LME functions performed by the other LMEs in the agreement (DMHDDSAS contract). ["All parties" includes other LMEs and subcontractors.]			
8. Neither the LME, nor any employee of the LME, applying to operate a PIHP shall serve as legal guardian for any recipient of Medicaid reimbursed mental health, developmental disabilities or substance abuse services. If the LME or any of its staff is currently the guardian for individuals who receive Medicaid services, submit a plan to transfer guardianship. This plan must include the number of individuals (wards) effected and a timeline for the total transfer of guardianship.	Scope of Work: Minimum Requirements		
9. The LME applying to operate a PIHP shall not contract with, or make any referral of a recipient to, any provider entity in which the LME or any member of the LME staff or a board member has an interest. • Interest means having a familial or financial relationship with the provider agency or any of its investors, owners, board members or employees. Financial relationship means contractual or employment arrangement; arrangement involvement a commission, reward, or other financial, material or tangible consideration or benefit.	DMA Contract, Section 1.8		
10. The LME applying to operate a PIHP shall maintain			

REQUIREMENTS	REFERENCE	Page Number(s)	Ö
professional liability insurance for itself and its professional staff with limits of at least ($1,000,000) per occurrence and at least ($3,000,000) in the aggregate throughout the terms of the contract by the time the contracts are signed. Submit copies of all current insurance certificates. Include one copy of each of medical malpractice, general liability, professional liability, fire/property, and workers compensation.	RFA, p. 37, Indemnity & Insurance		
11. The LME applying to operate a PIHP must possess or subcontract for and maintain an automated management information system capable of performing all the activity, interfacing and reporting requirements of a managed care organization utilizing electronic data interchange using HIPAA transactions, including claims adjudication, third party coordination, eligibility maintenance, membership reconciliation, provider and fee schedule maintenance, capitation payment reconciliation, financial reporting and encounter data creation and submission. The system must have the ability for provider access to check the status of their service authorization requests, claims submission and claims payment status. The system shall be fully capable of supporting and carrying out all required managed care functions 60 days before the start date. The LME shall provide a plan of how the management information system will be made ready. If there is to be development to be completed by a third party vendor, the LME must include with its application, the vendor's project plan (or at minimum business agreement) for completing the development within the required timeframe.	DMA Contract, Section 7.9		
12. The LME applying to operate a PIHP shall provide letters of support from the local Consumer and Family Advisory Committee (CFAC) of the LME that is submitting the application plus letters of support from any other CFACs that are part of the total configured population.	Scope of Work: Minimum Requirements		
13. The LME applying to operate a PIHP agrees to abide by all requirements contained in this RFA and the DMA Contract and the DMH/DD/SAS Contract attached to this RFA, and any subsequent changes negotiated in future contracts or as required by the federal Centers for Medicare and Medicaid Services (CMS).	Application Face Sheet		
14. The LME applying to operate a PIHP must hold a minimum of one (1) stakeholder meeting providing accurate information regarding the waiver and must submit minutes of the meeting as evidence.			

REQUIREMENTS	REFERENCE	Page Number(s)	Ö
15. The LME shall provide a letter of commitment to be operational no later than January 1, 2013 and to pass two readiness reviews prior to start date and that indicates the understanding that failure to meet these benchmarks will result in termination of the award. ❖ The letter signed by the LME Director and LME Board Chair, and if a single county, signed by the County Commissioner Chair.			

Appendix D. Implementation Plan

IMPLEMENTATION PLAN **Applying LME:** *[Enter Name of Applying LME]*

Instructions: Use this template as a guide for developing the Implementation Plan. The list below does not present an exhaustive list of tasks. Tasks and subsets of tasks may be added. Target dates are the number of days from contract execution; Assigned Department may be IT, Care Management, Customer Service, QI, etc.

Target Date	Assigned Department & Staffing Needs	Financial Resources (Link to Financial Plan)	Task
			Administrative Operations - Facilities and Organization
			Organizational function chart and responsibilities finalized
			Key staff employed, including:
			Medical Director
			Finance Director
			Contract/Project Manager
			Quality Management Director
			Customer Services Director
			Provider Network Director
			I/DD Clinical Director
			Management Information System Director
			Utilization Management Director
			All sites equipped and established for operations
			NCQA/URAC accreditation application submitted
			Employee Training Plan developed regarding:
			Clinical Specialties - Child & Adolescent, Adult MH, DD, SA, TBI, Co-occurring
			Evidenced based practices for specific disorders frequently encountered
			Clinical guidelines
			Guidelines for reporting quality of care concerns
			Guidelines for reviewing and reporting concerns related to psychotropic medications
			Due process

Target Date	Assigned Department & Staffing Needs	Financial Resources (Link to Financial Plan)	Task
			EPSDT
			Person centered planning and crisis planning
			Service definitions and clinical coverage policies
			Medical necessity criteria
			Provider and Recipient Interactions
			All procedures and processes described in SOW
			Additional Training topics: [specify]
			Project Readiness Reviews:
			Readiness review 90 days prior to Start Date:
			Readiness review 45 days prior to Start Date:
			Administrative Operations - LME-MCO Organizational Arrangements
			Organizational arrangement established and subcontracts secured
			All collaborative partnerships and formal agreements with business affiliates implemented
			Community stakeholder committees or groups established with meetings scheduled
			Administrative Operations - Health Information System
			Management Information System installed, tested, and fully operational
			Policies and procedures finalized for Management Information System department
			Long range strategic IT plan updated
			Management Information System staff employed based on job descriptions
			Management Information System staff trained according to training plan
			Supervision, oversight and monitoring protocols implemented
			Migration plan implemented
			Administrative Operations - Records
			All clinical care and service management records maintained as required
			Providers instructed and monitored regarding the maintenance of clinical care records

Target Date	Assigned Department & Staffing Needs	Financial Resources (Link to Financial Plan)	Task
			Administrative Operations - Encounter Data and Claims
			Policies and procedures finalized for utilization review and resource management and submission of claims
			Encounter data and claims staff employed based on job descriptions
			Encounter data and claims staff trained according to training plan
			Supervision and monitoring protocols implemented
			Reports generated and reviewed for accuracy
			Internal controls regarding fraud and abuse activated
			Administrative Operations - Financial Reporting Requirements
			Financial staff employed based on job descriptions
			Financial staff trained according to training plan
			Supervision and monitoring protocols implemented
			All financial reports generated and reviewed for accuracy
			Administrative Operations - Clinical Reporting Requirements
			All clinical performance reports generated and reviewed for accuracy
			Staff trained in the use of performance reports to manage and improve services
			Administrative Operations - Fraud and Abuse
			Policies and procedures finalized and implemented for guard against fraud and abuse
			Supervision and monitoring protocols implemented
			Administrative Operations - Subcontracts
			Prior written approval obtained from DHHS for subcontracting each administrative or clinical function
			Functions subcontracted implemented and tested and approved as operating as required
			Administrative Operations - Timeliness of Provider Payments
			Policies and procedures finalized and implemented for ensuring prompt payment to providers
			Supervision and monitoring protocols implemented

Target Date	Assigned Department & Staffing Needs	Financial Resources (Link to Financial Plan)	Task
			Administrative Operations - Financial Management/Monitoring
			Policies and procedures finalized for financial management department
			Internal controls and systems to ensures accurate accounting implemented
			Financial Management staff employed based on job descriptions
			Financial Management staff trained according to training plan
			Supervision and monitoring protocols implemented
			Plan for managing and reporting the risk reserve
			Clinical Operations - Customer Services
			Policies and procedures finalized for customer services department
			Toll free telephone access and 24/7 emergency referral operational
			Website and educational materials for customers prepared
			Customer Services staff employed based on job descriptions
			Customer Services staff trained according to training plan
			Supervision and monitoring protocols implemented
			Clinical Operations - Care Management
			Policies and procedures finalized for care management department
			Process for monitoring recipients with special health care needs implemented
			Care Management staff employed based on job descriptions
			Care Management staff trained according to training plan
			Supervision and monitoring protocols implemented
			Clinical Operations - Utilization Management
			Policies and procedures finalized for utilization management department
			Monitoring protocols implemented
			Utilization Management staff employed based on job descriptions
			Utilization Management staff trained according to training plan, including MIS
			Supervision and monitoring protocols implemented
			Transition plan developed for Supports/Comprehensive recipient transitions
			Clinical Operations - Quality Management

Target Date	Assigned Department & Staffing Needs	Financial Resources (Link to Financial Plan)	Task
			Quality Management plan, policies and procedures finalized for quality management department
			Monitoring protocols for QM implemented
			Quality Management staff employed based on job descriptions
			Quality Management staff trained according to training plan
			Quality Management committee(s) established
			Internal QA/QI operations implemented
			Improvement initiatives defined and program implemented
			Clinical Operations - Enrollee Grievances and Appeals
			Job descriptions prepared
			Policies and procedures finalized for grievances and appeals
			Enrollee grievances and appeals staff employed
			Training plan for Enrollee Grievances and Appeals staff developed and staff trained
			Consumer education materials regarding grievances and appeals developed
			Clinical Operations - Provider Network Management
			Provider network plan, policies and procedures finalized for Provider Network department
			Strategies to recruit, train, retain, and monitor providers implemented
			Provider Network staff employed based on job descriptions
			Provider Network staff trained according to training plan
			Provider Manual completed and distributed to providers
			Adequacy of network assessed and gaps analysis published
			Transition process from open to closed network implemented
			Evergreen contracts developed with all providers; contracts offered
			Provider training plan developed for:
			LOCUS, CALOCUS, SIS
			managed care appeals process
			authorization process, claims processing
			Additional Training topics: [specify]